Team KY Fund
Employment Verification

Date: _____

Applicant: _____ Social Security Number: _____

Employer: _____ Supervisor: _____

FEIN: _____

Telephone: _____ Email: _____

Address: _____

_____

City: _____ State: _____ Zip: _____

_____ hereby authorizes _____

Applicant Employer

to submit/verify the following information to Community Action Kentucky, Commonwealth of Kentucky, or other representatives of the Team Kentucky Fund. Your prompt attention to this matter will be greatly appreciated.

VERIFICATIONS BELOW TO BE COMPLETED BY EMPLOYER ONLY

Yes No

☐ ☐ Was the applicant named above employed by you or your organization on on a full-time basis (meaning employment that averaged at least thirty (30) hours per week) on or after March 6, 2020?

☐ ☐ Was the applicant terminated, laid-off, or had their wages reduced by more than fifty percent (50%) of gross earned income on or after March 6, 2020, because of the COVID-19 state of emergency?

The items listed below are to be **weekly amounts:**

2019 Individual Gross Earnings: $ _____ Individual Gross Earnings on or after March 6, 2020: $ _____

I hereby swear or affirm the information provided on this document is true and accurate. I further agree that the Commonwealth of Kentucky, Community Action Kentucky, Inc. or other representatives of the Team Kentucky Fund are permitted to independently verify any of the information contained herein, and that I will cooperate with such verification efforts.

Employer's or Designee's Signature**:** _____ / / _____

Date

Employer's or Designee's Name and Title: _____

Please return completed form to the following address:

Address: _____

_____

City: _____ State: _____ Zip: _____